The State of Kansas may contract on a risk basis with federally qualified HMOs and with entities that are not federally qualified HMOs but which meet the State definition of an HMO for the services specified in Title 42 CFR Section 434.21. Under the State's definition of an HMO, the HMO must meet the following requirements:

(1) Be organized primarily for the purpose of providing health care services;

(2) Make the services it provides to its Medicaid enrollees as accessible to them in terms of timeliness, amount, duration, and scope as those services are to non-enrolled Medicaid beneficiaries within the area served by the HMO;

(3) Make provision, against the risk of insolvency, and assure that Medicaid beneficiaries will not be liable for the HMO's debts if it does become insolvent;

(4) Be a risk-bearing entity licensed by the Kansas Department of Insurance and meeting Kansas Department of Insurance requirements for that class of licensure and meeting technical requirements outlined by the state in the Medicaid HMO Request for Consideration and the contract with the risk-bearing entity; and

(5) Meet all requirements of the appropriate HMO waiver as approved by HCFA.

Any contract between the State and a federally qualified HMO or an entity that meets the State's definition of an HMO must meet the applicable requirements contained in Title 42 CFR Section 434.6, Subpart C, and Subpart D.